



**New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor**

**Department of Human Services
Division of Medical Assistance and Health Services
Federally Qualified Health Centers**

July 1, 2010 through November 30, 2014

**Stephen M. Eells
State Auditor**



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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Federally Qualified Health Centers for the period of July 1, 2010 through November 30, 2014. If you would like a personal briefing, please call me at (609) 847-3470.

A handwritten signature in black ink, appearing to read "Stephen M. Eells".

Stephen M. Eells
State Auditor
May 13, 2015

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Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (the division), Federally Qualified Health Centers (FQHCs) for the period July 1, 2010 through November 30, 2014. FQHCs are federally supported, community-based health centers that provide comprehensive, primary health care services to medically underserved communities and vulnerable populations. Currently, there are 20 FQHCs operating in New Jersey. During calendar year 2013, FQHCs were reimbursed \$122.7 million for Medicaid services of which \$34.3 million were for supplemental (wraparound) payments. Fifty percent of the cost of Medicaid services is funded by the federal government.

Background

Federally Qualified Health Centers (FQHCs) provide comprehensive community-based primary health care to medically underserved populations. Most FQHCs are located in urban or rural areas. They are federally licensed. Federal guidelines regulate FQHC reimbursement payments for services provided to Medicaid beneficiaries and require that FQHCs are reimbursed their reasonable costs associated with providing Medicaid services. State Medicaid agencies are required to pay FQHCs either on a prospective payment system (PPS) or an alternative payment methodology (APM) for face-to-face encounters between a Medicaid beneficiary and one of the center's billable providers. New Jersey utilizes the APM. These rates are adjusted annually by the Medicare Economic Index. Rates are also subject to change when a FQHC changes the services it provides, including adding or closing a location. APM rates currently range from \$135 to \$150 per visit.

New Jersey, like many other states, contracts with HMOs to deliver health care services to Medicaid-eligible individuals. HMOs subcontract with providers, including FQHCs to provide medical services, and reimburse FQHCs for Medicaid-eligible encounters. The contracted payments from the HMOs to the FQHCs are often less than the amount the FQHCs are entitled to receive under the APM rate. Medicaid regulations require the state to make a wraparound payment for the difference between the HMO/other third-party payments and the APM amount.

As a result of a lawsuit, beginning in 2013, FQHCs must provide claim level data supporting their quarterly invoices requesting wraparound payments. Prior to that time, FQHCs were not providing detailed claim information to the division.

Objectives

The objectives of our audit were to determine whether encounters submitted for wraparound reimbursements by the FQHCs were properly supported. An additional objective was to determine whether medical records and the related reimbursements agreed with the claims data recorded in the New Jersey Medicaid Management Information System (NJMMIS).

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In preparation for our testing, we studied legislation, the administrative code and policies of the division. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our review of medical claims and payments to the FQHCs. We interviewed division personnel, as well as individuals employed by the FQHCs and the Health Maintenance Organizations (HMOs), to obtain an understanding of the claim process and payments to the FQHCs.

A nonstatistical sampling approach was used. Our samples were designed to provide conclusions about the payment process relating to FQHCs including the reasonableness and the accuracy of the encounter documentation, and compliance with internal policies, as well as both federal and state requirements. Sample populations were sorted and transactions were randomly and judgmentally selected for testing.

Conclusions

We found encounters that were submitted by the FQHCs to the division for wraparound reimbursements that were not properly supported. In addition, we found medical records and the related reimbursements that did not agree with the claims data recorded in the New Jersey Medicaid Management Information System (NJMMIS). In making these determinations, we found FQHCs that did not submit changes in scope information to the division which could result in an adjustment to their reimbursement rate, quarterly invoices for wraparound reimbursements did not identify receipts from third parties and may have resulted in overpayments to the FQHCs, and the division does not review the servicing providers on fee-for-service claims to determine if they are approved Medicaid eligible providers, as well as other reportable conditions. We also observed that the FQHCs are not submitting wraparound invoices timely, nor are they fully utilizing the division's appeal process to challenge the HMOs' determinations of invalid Medicaid claims.

Unsupported Invoices

The division reimbursed FQHCs for encounters that were not approved in the New Jersey Medicaid Management Information System (NJMMIS).

In calendar year 2011, the division began requesting FQHCs to provide HMO claim level data prior to paying wraparound reimbursements. If FQHCs were unable to produce this information, the division would calculate the quarterly wraparound payments using the approved HMO data recorded in the NJMMIS, because encounters in the NJMMIS indicate that an HMO reviewed and processed the claim after determining the individual, service, and the provider were eligible for payment. Prior to this, FQHCs did not provide supporting documentation to the division and the division did not use NJMMIS to calculate the payment, and therefore, there was no review to ensure the accuracy of the information provided. The FQHCs objected to the 2011 claim level review enhancements being conducted by the division and sued the state. The United States District Court ruled that the state could not calculate wraparound payments in this manner and ordered immediate emergency payments to FQHCs in the amount they would have received under the prior methodology. The state appealed and in calendar year 2013 the United States Court of Appeals overturned the lower court and did require FQHCs to provide claim level detail supporting the encounters reported to the division with the quarterly wraparound invoices. This ruling requires FQHC claims be submitted to the HMOs' claim processing system for an HMO eligibility and payment determination prior to the FQHCs submitting the encounter to the division for a wraparound payment. In our testing of activity prior to the court ruling, we compared FQHC quarterly invoiced amounts for service dates from July 2010 through December 2012, totaling \$96.5 million, to the NJMMIS. We determined that the state reimbursed FQHCs for 141,837 encounters totaling \$9 million in wraparound payments for encounters that were not approved by the HMOs in the NJMMIS.

Since the 2013 court ruling, any request for a wraparound payment by an FQHC must be properly supported by claim data; otherwise it is determined to be incomplete and ineligible for processing. The following chart summarizes wraparound reimbursements after the division's review process.

1st Qtr. 2013 through 2nd Qtr. 2014 as of 10/17/2014

	Encounters	Percentage Denied	Wraparound
Requested by the FQHCs	844,039		\$68,622,296
Not Approved by HMO	44,602	5.29%	
Not Processed by HMO	40,542	4.80%	
Incorrect Medicaid ID #s	7,990	0.95%	
Non Billable Encounters	2,382	0.28%	
Duplicate Encounters	3,070	0.36%	
Previously Paid	13,337	1.58%	
Total Denied	111,923	13.26%	\$15,698,524
Total Validated and Paid	732,116		\$52,923,772

After the court ruling, \$15.7 million or nearly 112,000 encounters (13.3 percent of the requested encounters) were denied payment. Prior to the court ruling, the division would have paid for these ineligible encounters.

In addition, we requested claim data directly from 17 FQHCs, for three quarters from 2010 to 2012, a period when they were not required to submit documentation. The centers could not provide adequate supporting documentation. Differences were noted in the number of encounters, receipt amounts, and prior period adjustments that were being reported by the FQHCs.

Recommendation

We recommend that the division continue also to rely on the HMOs' review process to determine whether a claim is Medicaid eligible, and also continue to require all detailed claim level data from the FQHCs to ensure the proper and efficient payment of claims.



Inaccurate Billings

FQHC invoices submitted to the division should be accurate and verifiable.

We judgmentally selected six FQHCs to identify high risk encounters for calendar years 2012 and 2013. We identified 4,656 encounters for which we sampled 503 that were either denied by HMOs, not found in the NJMMIS, or were for ineligible procedure codes. We visited the six FQHCs and traced the encounters to patient medical records and reviewed the HMOs' Explanation of Benefits (EOBs), as well as billing documents submitted by the FQHCs. Our review included the following.

- We could not trace service providers on the FQHC billing documents to medical records for 117 (23%) encounters tested. FQHCs billed services under other provider's National Provider Identification number. Service providers must be credentialed by the HMOs or the claim will be denied. Some FQHCs billed for services using a credentialed provider to ensure reimbursement, even though the provider did not provide the service. This practice is inappropriate and should be further investigated by the division. In addition, non-credentialed providers may impact the quality of care.
- We found that 170 (34%) of the encounters tested did not agree with the amounts stated on the HMOs' EOBs because services were either denied by the HMOs or the amounts provided by the FQHCs did not agree with the HMOs' reimbursement amounts. Understating HMO reimbursement amounts on FQHCs quarterly invoices will result in overpayments in the wraparound reimbursement by the division.

- Procedure codes provided by the FQHCs as a part of their encounter documentation did not agree with the procedure codes on the billing documents submitted to the HMOs for 48 (10%) of the encounters tested.

Recommendation

We recommend the division review to determine that FQHCs accurately state the servicing providers and the procedure codes on the billing documents to the HMOs. In addition, the division should not rely on information provided by the FQHCs regarding HMO reimbursement amounts. This information should be obtained directly from the HMOs.



Change in Scope of Service

FQHCs did not submit required change in scope of service applications which could affect their Alternate Payment Methodology (APM) rates.

The New Jersey Administrative Code (N.J.A.C.) 10:66-1.5(i) defines a change in scope of service as an addition of a new FQHC covered service that is not incorporated in the baseline APM rate or a deletion of an FQHC covered service that is included in the baseline rate. A change in scope of service could also include relocation, remodeling, opening a new center, or closing an existing center. The regulation also states that FQHCs shall notify the division, in writing, at least 60 days prior to the effective date of any changes, and the reason for the changes. A change of scope may cause a revision in the APM rate depending upon whether the change in services impacts the center's costs.

We visited six FQHCs and determined that five centers had 67 changes in scope of service. However, only nine were submitted to the division and only two resulted in an adjustment to the providers' APM rates. The other seven changes did not result in an APM adjustment because the applications were incomplete. We noted the following issues within the 67 changes of scope.

- One center opened seven school-based health centers between 2006 and 2012, and later closed two of those centers without submitting any change of scope application.
- In 2005, a center purchased two mobile units which have not been utilized for several years. The center did not submit an application for the opening of the units, nor did they notify the division when they discontinued using them.
- Six applications were submitted by one center dating back to 2004 that affected the cost; however, no adjustments were made to their APM rate. In 2009, they submitted a letter to the division requesting a retraction of all prior applications because it was not their intention to apply for a rate change, but only to inform the division of their new services.

The division's management asserts that when the FQHCs have applied for changes in scope of service, the applications have been incomplete. When the division requests further documentation, most centers do not respond and the rates are not adjusted. FQHCs cite ambiguity in the administrative code as the reason for not submitting applications; however, the division believes the regulations are clear on the requirements.

Recommendation

We recommend the division require FQHCs to comply with the language stated in the N.J.A.C. so that all changes in scope of service are submitted timely and not at the discretion of the FQHC, and accurately reviewed by the division so that rates can be appropriately adjusted. In addition, the division should follow-up with the FQHCs when change in scope of service applications are incomplete.

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Obstetrics - Gynecology (OB/GYN) Reimbursements

The division overpaid \$267,000 in reimbursements because the APM rate included OB/GYN costs that were paid separately.

In response to FQHC concerns and in an effort to support the centers to perform OB/GYN services, in 2008, the division began excluding OB/GYN deliveries and specific surgical services from the APM rate, and instead, began reimbursing separately at a higher rate that is more reflective of the actual costs of these services. Although the OB/GYN deliveries and surgical services are paid a separate reimbursement rate, four FQHCs' APM rates still include costs related to OB/GYN services. We determined that the division overpaid these FQHCs \$267,000 for all encounters from the third quarter of calendar year 2010 through the first quarter of 2014 because they were reimbursed at the inflated APM rate.

Recommendation

We recommend that the division adjust the APM rates and deduct the portion of the rate related to the OB/GYN deliveries and the specific surgical procedures so that the state does not continue to overpay the FQHCs for Medicaid services.

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Visits Per Day

The New Jersey Administrative Code (N.J.A.C.) is not in compliance with the federal requirements regarding the number of visits per day that qualify for Medicaid reimbursement.

The federal *Medicare Claims Processing Manual* for Rural Health Clinics and FQHCs, Chapter 9, section 20.1 states, "Encounters with more than one health professional and multiple encounters with the same health professionals which take place on the same day and at a single location constitute a single visit... unless the patient has a medical visit and a clinical psychologist or clinical social worker visit." N.J.A.C. states, "Normally, only one medical encounter is covered per beneficiary, per day. More than one medical encounter is covered, however, when the beneficiary is seen by more than one licensed practitioner for the prevention, treatment or diagnosis of different injuries or illnesses, and practitioners of appropriate different specialties are involved." Based upon our review of both criteria, it appears that the N.J.A.C. is not in agreement with the federal requirements because the N.J.A.C. allows for more than one medical encounter being covered when the beneficiary is seen by more than one health professional for different illnesses in the same day, while the federal requirement only allows for one visit per day whether the beneficiary is seen by one health professional or more than one health professional in the same day. As a result, the division over reimbursed FQHCs \$1.7 million in wraparound payments for 12,400 encounters from the third quarter of 2010 through the fourth quarter of 2012 because the N.J.A.C. 10:66-4.1 is not in compliance with the federal requirements. The administrative code needs to be amended to comply with the federal requirements.

Recommendation

We recommend that the division comply with the federal requirements and amend the administrative code so that the division does not continue to reimburse the FQHCs for Medicaid encounters over the federal limits.



Receipts from Third Parties

Receipts from third parties in the amount of \$933,000 were not identified on the quarterly invoices.

Medicaid beneficiaries may have access to other health care (third-party) coverage in addition to qualifying for Medicaid. All receipts from third-party coverage and co-payments from Medicaid HMOs, as well as Medicaid beneficiaries, are to be subtracted from the quarterly invoices to determine the amount the division will pay to the FQHCs for the wraparound payment. We have determined that from July 1, 2010 through June 30, 2014, the FQHCs quarterly invoices and support did not identify third-party receipts in the amount of \$933,000.

The invoices only identified receipts from the HMOs, making it difficult to determine whether or not third-party receipts were properly deducted from the requested invoiced amounts.

Recommendation

We recommend the division require FQHCs to properly identify receipts from third parties on the quarterly invoices to ensure wraparound payments are not overpaid.



Reimbursement Process

The division should consider having the HMOs reimburse the full APM rate, including the wraparound payment, directly to the FQHCs to ensure proper reimbursement.

The division relies on the FQHCs to submit only encounters paid by the HMOs for wraparound reimbursement. Prior to reimbursement, the FQHCs' reported encounter data should reconcile with the HMOs' data in the New Jersey Medicaid Management Information System (NJMMIS). Based on encounters submitted by the FQHCs and paid by the division for the first and second quarters of calendar year 2013, we found we could only reconcile 60 percent of the claim level data for 18 FQHCs. We then reconciled six FQHCs' encounter data by date of service only, and found 90 percent of the encounters could be reconciled to the NJMMIS. However, with both reconciliations we noted HMO receipts reported by the FQHCs did not agree with the receipts recorded on the NJMMIS. Because the division relies on the HMOs' review process prior to reimbursing FQHCs for wraparound payments, it would be more efficient and accurate for the HMOs to reimburse the FQHCs directly for the full APM rate which would include the HMO Medicaid reimbursement along with the supplemental wraparound payment. The division would then reimburse the HMOs for the amount of the wraparound payment while monitoring the HMOs for proper processing.

Recommendation

The division should amend the HMO contracts to have the HMOs reimburse the FQHCs for the full APM rate allowing for more efficient and accurate reimbursements to the FQHCs.



Fee-for-Service Servicing Providers

FQHC fee-for-service (FFS) claims should be subject to NJMMIS edits when identifying service providers.

Pursuant to federal regulation 42CFR 455.410, all ordering and referring physicians or other professionals providing services under the Medicaid program are required to be enrolled as a participating provider. Due to system limitations within NJMMIS, the division had to circumvent edits when reviewing servicing providers for FQHC FFS claims because the system is unable to identify the various types of clinicians practicing at the FQHCs. All FQHC FFS claims, amounting to \$86.3 million from calendar year 2012 through October 3, 2014, were not subjected to the servicing provider edits through NJMMIS. As a result, FFS claims would not be denied if the servicing providers were ineligible to participate in the Medicaid program. In addition, FQHCs are not properly identifying the servicing providers on FFS claims. Our review of these claims noted that approximately 86 percent of the FFS claims, or 1.3 million claims totaling \$75.6 million, identified the servicing providers as the FQHC rather than the individual practitioners who performed the services.

Recommendation

We recommend the division discontinue the practice of circumventing edits and enhance NJMMIS to properly review the service providers on FQHC FFS claims to ensure that providers are eligible to participate in the Medicaid program. In addition, the division should require FQHCs to identify the service providers on all FFS claims.



Observation

Timeliness of Invoices and the Appeal Process

FQHCs are not submitting wraparound invoices timely and the appeal process is not fully utilized.

FQHCs are required to provide claim level data supporting their quarterly wraparound invoices including HMO payment amounts and payment dates because the division relies on HMOs to determine whether a claim is Medicaid eligible. The New Jersey Primary Care Association, Inc., which represents the FQHCs, disagreed with this process and sued the state claiming that HMOs deny claims for many reasons unrelated to whether or not the encounter was covered under Medicaid, thus delaying Medicaid wraparound payments to the FQHCs. Federal Courts' decisions confirmed that the division has the authority to require detailed claim level data from the FQHCs as well as the HMO payment amounts and payment dates, to ensure the proper and efficient payment of claims and management of the program. The division, in order to conform to the opinion, implemented an appeal process for FQHCs to challenge claims denied by the HMOs and the division.

The review process, along with the appeal process, was initiated during the first quarter of calendar year 2013 requiring FQHCs to provide supporting documentation along with their quarterly wraparound invoices. The division requests the FQHCs submit their quarterly invoices within 55 days after the end of each quarter. We reviewed the 113 paid invoices submitted after January 1, 2013 through November 13, 2014 from 19 FQHCs and found only 44 invoices were submitted timely. Thirty-five invoices were submitted over 100 days after the quarter ended. Based on our review, the division took an average of 47 days to reimburse FQHCs, meeting the federal requirement of timely payments being made within four months from the receipt of the invoice.

We also noted that of the 113 invoices submitted by the FQHCs, 111 were not paid the full wraparound amount requested and included claims that the FQHCs could appeal. A total of \$54.8 million was paid by the division, while \$16 million in claims were denied payment. However, the FQHCs only appealed some of the claims on 21 of the 111 invoices, amounting to \$1.3 million. Eighty-one percent of the invoices were not appealed. Furthermore, the division requires that a FQHC wishing to challenge an HMO's determination of an invalid Medicaid claim, has 15 days from the FQHCs receipt of the encounter file with the denied encounters, to initiate an appeal process with the division. We determined only 4 of the 21 invoices were appealed within the 15-day requirement, while 17 invoices were appealed after 15 days. This includes nine invoices being appealed more than 50 days after receiving the file.

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State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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May 11, 2015

John J. Termyna, Assistant State Auditor
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125 South Warren Street
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Trenton, NJ 08625-0067

Dear Mr. Termyna:

This is in response to your letter to Acting Commissioner Connolly concerning the Office of Legislative Services' (OLS) draft audit report entitled "**Department of Human Services, Division of Medical Assistance and Health Services, Federally Qualified Health Centers.**" The period of the audit was from July 1, 2010 through November 30, 2014. Your letter provides an opportunity for the department to comment on the draft audit report.

Per the report, the objective of the audit was to determine whether encounters submitted for wraparound reimbursements by the Federally Qualified Health Centers (FQHCs) were properly supported. An additional objective was to determine whether medical records and the related reimbursements agreed with the claims data recorded in the New Jersey Medicaid Management Information System (MMIS)

The draft audit report concluded that some of the encounters submitted by the FQHCs for wraparound reimbursements were not properly supported and that some of the medical records and the related reimbursement did not agree with the claims data recorded in the MMIS system possibly resulting in overpayments to the FQHCs. The auditors also observed that the FQHCs were not submitting wraparound invoices timely, nor were they fully utilizing DMAHS's appeal process to challenge the HMOs' determinations of invalid Medicaid claims.

Unsupported Invoices:

Recommendation:

DMAHS should continue to rely on the HMO's review process to determine whether a claim is Medicaid eligible, and also to continue to require all detailed claim level data from the FQHC to ensure the proper and efficient payment of claims.

Response:

DHS agrees with the recommendation.

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Assistant State Auditor
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The Third Circuit's Opinion affirms the federal requirement that States participating in the Medicaid program provide for procedures of pre-payment and post-payment claims review in order to ensure the proper and efficient payment of claims and management of the program. In order to strengthen that claims review, DMAHS relies on HMOs to determine whether a claim is Medicaid-eligible, a practice that the Court found to be consistent with federal Medicaid law. DMAHS continues to require all detailed claim level data to be provided by the FQHCs for reported encounters, including HMO payment information.

Inaccurate Billings:

Recommendation:

DMAHS should review to determine that FQHCs accurately state the servicing providers and the procedure codes on the billing documents to the HMOs. In addition, DMAHS should not rely on information provided by the FQHCs regarding HMO reimbursement amounts. This information should be obtained directly from the HMOs.

Response:

DMAHS no longer relies upon FQHC self-reported HMO payment information. The Third Circuit's decision and the District Court's Order confirmed that DMAHS has the authority to require detailed claim level data from FQHCs for reported encounters, as well as the HMO payment amount and HMO payment date. Additionally, under the decision, DMAHS is within its statutory and regulatory authority to require claim level data in order to ensure the proper and efficient payment of claims and management of the program.

Change in Scope of Service:

Recommendation:

DMAHS should require FQHCs to comply with the language stated in the N.J.A.C. so that all changes in scope of service are submitted timely and not at the discretion of the FQHC, and accurately reviewed by the division so that rates can be appropriately adjusted. In addition, DMAHS should follow-up with the FQHCs when change in scope of service applications is incomplete.

Response:

DHS agrees with these recommendations and will renew efforts with the FQHC industry to move forward in the area of Change-In-Scope of Service.

Obstetrics – Gynecology (OB/GYN) Reimbursements:

Recommendation:

DMAHS should adjust the APM rates and deduct the portion of the rate related to the OB/GYN deliveries and the specific surgical procedures so that the state does not continue to overpay the FQHCs for Medicaid services.

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Assistant State Auditor
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Response:

In 2008, DMAHS modified the payment methodology for deliveries, specified Ob/Gyn surgeries and surgical assistants to encourage FQHCs to perform these services. DMAHS will evaluate this policy in connection to all the OLS recommendations contained within this report.

Visit Per Day:

Recommendation:

DMAHS should comply with the federal requirements and amend the administrative code so that the division does not continue to reimburse the FQHCs for Medicaid encounters over the federal limits.

Response:

DMAHS will work with the Centers for Medicare & Medicaid Service (CMS) to review the State's current payment methodology and State Plan Amendment (SPA) for compliance with federal requirements. If an adjustment is deemed necessary, DMAHS will take action to amend the SPA and administrative code.

Receipts from Third Parties:

Recommendation:

DMAHS should require FQHCs to properly identify receipts from third parties on the quarterly invoices to ensure wraparound payments are not overpaid.

Response:

DMAHS shall take this recommendation into consideration as it continues to monitor and strengthen the current wraparound/supplemental reimbursement process.

Reimbursement Process:

Recommendation:

DMAHS should amend the HMO contracts to have the HMOs reimburse the FQHCs for the full APM rate allowing for more efficient and accurate reimbursement to the FQHCs.

Response:

This is an HMO contract change that has been discussed and considered for many years within DMAHS and with the FQHC industry. DMAHS will consider this OLS recommendation and reevaluate the merits of its implementation.

John J. Termyna
Assistant State Auditor
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FQHC fee-for-service (FFS) claims should be subject to NJMMIS edits when identifying service providers:

Recommendation:

DMAHS should discontinue the practice of circumventing edits and enhance MMIS to properly review the service providers on FQHC FFS claims to ensure that providers are eligible to participate in the Medicaid program. In addition, DMAHS should require FQHCs to identify the service providers on all FFS claims.

Response:

DMAHS is aware that FQHCs may submit claims with the identical billing and servicing provider numbers and is working to enhance the claim edit.

Timeliness of Invoices and the Appeal Process:

Observation:

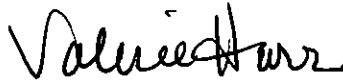
FQHC's are not submitting wraparound invoices timely and the appeal process is not fully utilized.

Response:

DMAHS agrees with the observation.

If you have any questions or require additional information, please contact me or Richard Hurd at 609-588-2550.

Sincerely,



Valerie Harr
Director

VH:H

c: Beth Connolly
Richard Hurd